Advanced MEPRS and Financial Reconciliation

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

Burma Barfield

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UNCLASSIFIED

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

- **Standardized MEPRS reporting allows comparison of the same specialty care or function to allow for identification of outliers and anomalies.**
  - **Many sites contact AMPO to say their MTF created a ‘new’ service with a new name, and they need a new MEPRS code.**
  - **MEPRS personnel need to identify if the ‘new’ function is reorganization and renaming of existing personnel and function. Verification of the standardized TDA paragraph and line of personnel will assist in research. Adjustments to the standardized TDA may confuse research.**
  - **Regardless of what the ‘new’ service is named at the local level, it is important that the service continue to be reported in the designated standardized MEPRS codes.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

INPATIENT DATA:

- **Reporting inpatient data correctly in all systems can be tricky. The inpatient wards (A%X%) are inpatient physical standalone work centers, and the pure 'A' admission MEPRS codes are considered requesting inpatient services.**

- **With the exception of contract labor for credentialed providers who perform inpatient care, budget should never report contract expenses to a pure 'A' MEPRS code. Contractual obligation and expenses should only be charged to the inpatient ward MEPRS codes (A%X%) for inpatient ward nursing staff.**

  - **In all cases, local Budget should charge all civilian payroll, supplies and equipment to the physical inpatient ward work center (A%X%) where the nursing personnel work, and where the supplies and equipment are used.**

- **All inpatient expenses reported for an inpatient ward (A%X%) are allocated/step-down to the pure inpatient requesting specialties (AAAA, ABAA, etc) based on 1,440 minutes of service per OBD.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

INPATIENT DATA:

- **Although Intensive Care Units (ICUs) are normally considered inpatient wards, they are reported as ancillary services in MEPRS. The ICUs are reported in DJ%% MEPRS codes and are considered physical standalone work centers. The pure 'A' admission MEPRS codes are considered requesting inpatient services on the ICUs.**

- **Contract labor for credentialed providers should never be reported in an ICU MEPRS code since ICUs are dedicated nursing units.**

  - **In all cases, local Budget should charge all civilian payroll, supplies and equipment to the physical ICU work center (DJ%%) where the nursing personnel work, and where the supplies and equipment are used.**

- **All expenses reported for an ICU unit (DJ%%) are allocated/step-down to the pure inpatient requesting specialties (AAAA, ABAA, etc) based on hours of service reported per patient on the ICU.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

INPATIENT DATA (continued):

- **If Budget receives special funding for a new program, and they charge the obligations and expenses directly to a pure 'A' requesting inpatient MEPRS code instead of to the inpatient ward cost pool MEPRS code (A%X%), then the full cost for that pure 'A' requesting inpatient MEPRS code is distorted and overstated.**
  - **In this example, the pure 'A' requesting inpatient MEPRS code receives a cost allocation from the inpatient wards (A%X%) for all costs, as well as the direct expense charged by Budget.**
- **Inpatient civilian and military payroll salary expense are captured and allocated in DMHRSi based on where the individuals report their man-hours by inpatient MEPRS code.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

INPATIENT DATA (Continued):

- **Personnel (especially skill types 1 and 2) who are not assigned and/or dedicated to an inpatient ward are not authorized to report time to an inpatient ward or an ICU MEPRS code because these represent nursing standalone inpatient work centers. When this occurs, it generates an Unauthorized FTE in Ancillary Account discrepancy.**

- **Inpatient ward MEPRS codes should match on the CHCS MEPRS Monthly Activity Report, CHCS, EASIV, DMHRSi , and STANFINS/GFEBS. There should be no additional or test ward locations or MEPRS codes in CHCS. Pure inpatient 'A' MEPRS codes should never be used to report an inpatient ward since this will prevent accurate reporting of multiple specialties that may be placed on the nursing unit.**

- **Labor & Delivery is not an inpatient ward and is part of the Mother & Baby Unit. Labor & Delivery must have the same 4th level MEPRS code as the Mother & Baby Unit in all systems. L&D can have a separate location in CHCS, but must have the same MEPRS code as Mother & Baby Unit.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

INPATIENT DATA (Continued):

- **Sometimes MTFs try to create sub-nursing units within existing inpatient wards and ICUs to track patients who require less nursing care, a type of patient, etc. Nursing 'Step Down Units' are a good example of a type of nursing sub-unit created within an existing standalone nursing inpatient ward or ICU to take care of a certain type of patient.**

- **When this occurs, an additional MEPRS code or location in CHCS is not authorized since the nursing sub-unit is created within an existing inpatient ward or ICU. The infrastructure of the existing inpatient ward and/or ICU support the new nursing sub-unit.**

- **Creation of additional MEPRS codes or locations for nursing inpatient sub-units fractionalize reporting of the inpatient ward and/or ICU which in turn distorts the allocated costs to all inpatient specialties on these units.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

INPATIENT DATA (Continued):

- **Inpatients on ICU units are handled differently in CHCS than other inpatients. There are special ICU admission codes reported on the WWR report to indicate designated ICU patients.**

- **The unique ICU MEPRS codes (AAHA, ABCA, etc) are only allowed in CHCS and are part of the ICU file and table. These unique ICU MEPRS codes are for billing purposes only.**
- **When this occurs, an additional MEPRS code or location in CHCS is not authorized since the nursing sub-unit is created within an existing inpatient ward or ICU. The infrastructure of the existing inpatient ward and/or ICU support the new nursing sub-unit.**

- **Creation of additional MEPRS codes or locations fractionalize reporting of the inpatient ward and ICU which distorts the allocated costs to all inpatient specialties on these units.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

INPATIENT DATA (Continued):

- **All Clinical Nursing Staff should be reported as assigned and available to the inpatient ward or ICU where they are authorized, required, and available.**

- **Only the Department of Nursing is authorized an Administrative MEPRS code of EBDI. All previously reported administrative nursing MEPRS codes were supposed to be deactivated and Nursing staff realigned to clinical nursing units. Some sites transferred all of the previously reported Nursing staff in EBD% administrative MEPRS code to EBDI.**

- **Because EBDI allocates to all work centers with nursing personnel, overstated costs in EBDI, Department of Nursing distorts the cost of all patient care in the MTF when allocation is performed in EASIV.**

- **The Deputy Commander for Nursing should be reported in EBAA, Command Staff.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

INPATIENT DATA (Continued):

- **There is a new trend by some specialties (specifically Orthopedics) to take a Physician Assistant (PA) to the Operating Room with them as an assistant. The PA is a credentialed provider and is not a student.**

- **The physician and the PA want to report the PA's time in the OR to the Nursing Operating Room or to a training account . Neither of these options are authorized. Since the PA is not available in the outpatient clinic for scheduled appointments and is supporting the inpatient surgery, the PA should report this time as available to the inpatient specialty MEPRS code; i.e., Inpatient Orthopedic Surgery.**

- **This will result in a higher cost per inpatient disposition which will be accurate since two providers are involved in the surgery. Available time in the outpatient clinic is also less since the PA and the surgeon are not available for scheduled outpatient appointments.**

- **Credentialed providers should only have one inpatient MEPRS code.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING – INPATIENT DATA

- **The workload on the WWR, the CHCS Monthly Activity Report, and WAM for inpatient care should be reconciled on a monthly basis for accurate processing in EASIV.**

- **With the exception of DDEAMC, sites are not authorized to report inpatient admissions, OBDs, or dispositions for external workload performed in a civilian institution or VA.**

- **Only IBWA ward rounds which are reported as workload in an 'A' MEPRS code on an outpatient SADR are authorized for external workload agreements.**

- **All inpatient admission, OBDs, dispositions, and IBWA ward rounds should have credentialed provider man-hours reported in DMHRSi in the same 4th level MEPRS code. Workload and man-hours should be reconciled before DMHRSi is closed and interfaced into EASIV.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING – INPATIENT DATA

WHY IS THERE SUCH A VARIANCE IN FY09 TOTAL EXPENSE PER DISPOSITION FOR ALL INPATIENT CARE IN ARMY MTFs? EACH LINE ITEM BELOW REPRESENTS AN INDIVIDUAL MTF COST PER DISPOSITION. EXAMPLES OF VARIANCES PROVIDED BELOW. COPIES OF ORIGINAL EXCEL SPREADSHEETS ARE ON EACH DESKT

FY09 ARMY TOTAL AVERAGE EXPENSE PER DISPOSITION

4th Level Functional Cost Code	FY09 Total Average Expense Per Disposition
ADAA – PEDIATRICS	$46,991.96
	$37,607.69
	$12,961.92
	$11,171.34
	$7,481.95
	$7,438.83
	$7,041.53
	$6,266.06
	$5,562.67
	$5,491.86
	$5,217.12
	$5,106.05
	$4,994.54
	$4,797.63
	$4,717.81
	$4,609.56
	$4,465.67
	$4,167.53
	$3,592.49
	$3,543.67
	$2,440.50
ADAL – PEDIATRICS	$8,664.17

IMPORTANCE OF STANDARDIZED MEPRS REPORTING- INPATIENT DATA

WHY IS THE TOTAL COST PER DISPOSITION A MORE USEFUL MEASUREMENT THAN TOTAL COST PER OBD?

FY09 ARMY TOTAL AVERAGE EXPENSE PER DISPOSITION

4th Level Functional Cost Code	FY09 Total Average Expense Per Disposition
AABA – CARDIOLOGY	$24,613.26
	$15,423.76
	$13,766.09
	$9,862.88
	$8,940.85
	$8,326.04
	$6,366.62
	$2,469.09
AAEA – ENDOCRINOLOGY	$6,885.54
	$4,801.89
	$3,102.80
	$2,461.33
AAFA – GASTROENTEROLOGY	$14,429.31
	$11,849.62
	$11,036.10
	$10,982.98
	$8,161.25
	$1,719.13
AAGA – HEMATOLOGY	$12,093.62

IMPORTANCE OF STANDARDIZED MEPRS REPORTING- INPATIENT DATA

IF STANDARDIZED MEPRS REPORTING IS PERFORMED AT EACH ARMY MTF, THEN THE DIRECT AND INDIRECT COSTS SHOULD BE CONSISTENT. ARE THESE ACCURATE COSTS?

FY09 ARMY TOTAL AVERAGE EXPENSE PER DISPOSITION

4th Level Functional Cost Code	FY09 Total Average Expense Per Disposition
AAIA - NEPHROLOGY	$7,805.79
	$7,598.63
AAJA - NEUROLOGY	$13,757.05
	$13,647.25
	$13,259.62
	$6,591.76
	$5,344.45
	$4,937.59
AAKA - ONCOLOGY	$23,902.64
	$19,247.96
	$15,385.70
	$14,498.61
AALA - PULMONARY	$166,469.85
	$89,075.24
	$59,212.64
	$51,845.57
	$36,697.98
	$9,347.26
AANA - PHYSICAL MEDICINE	$21,960.05
AAQA - BONE MARROW TRANSPLANT	$56,422.36

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

PERSONNEL DATA:

- **A special DCPS pay tape is directly interfaced into DMHRSi for civilian payroll. EASIV uses civilian payroll expenses that are allocated in DMHRSi and does not use civilian payroll reported by Budget; however, there should not be more than a +/- 5% between DMHRSi and Budget civilian payroll.**
  - **One common reason that the variance is greater than +/- 5% is due to VET civilian payroll which is processed by Budget and not in EASIV.**
  - **Another reason for variance is because Budget has to estimate remaining civilian payroll amounts through the last day of the fiscal month whereas EASIV uses actual civilian payroll through the last day of the fiscal month.**
  - **Another problem exists if Budget over/under estimates civilian payroll by 5% at September year-end close-out , then both September and October (in both fiscal years) may have a greater than +/- 5% variance.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

PERSONNEL DATA (Continued):

- **There is also a problem when Budget adjusts civilian payroll for prior obligation years in a current fiscal month.**

- **EASIV creates civilian payroll obligations based on civilian payroll expenses when DMHRSi civilian payroll is interfaced into EASIV. For this reason, civilian payroll obligations should always equal civilian payroll expenses in EASIV. When this is not the case, there is usually an error.**

- **Budget should not create multiple APCs/Cost Centers to track and report civilian payroll costs based on where an individual may report available hours. Budget should report civilian payroll costs based on the assigned standalone work center MEPRS code.**

- **DMHRSi uses Military pay created from a standardized DoD Military Pay Composite Rate based on rank. These military pay salary expense amounts interface into EASIV. There should be no obligations for Military Pay.**

IMPORTANCE OF STANDARDIZED MEPRS REPORTING

PERSONNEL DATA (Continued):

- **EASIV purges/deletes the STANFINS civilian payroll obligations and expenses after STANFINS interfaces into EASIV because STANFINS civilian payroll does not report civilian payroll salary in all of the MEPRS codes where the civilian reported man hours in DMHRSi.**

- **Contract labor man-hours are also reported in DMHRSi, but contractual expenses are not captured or reported in DMHRSi.**

- **All contractual expenses are reported in STANFINS/GFEBS so it is important to align the contract expenses in STANFINS/GFEBS to the same MEPRS code where the contract man-hours are reported in DMHRSi.**

- **Contract salary expense and contract man-hours should interface into EASIV with the same 4th level MEPRS code, but it is a known problem that contracts are not written to report the contract labor expenses to the correct 4th level MEPRS code.**

QUESTIONS?